# Commonwealth of Kentucky
# Workers' Compensation Board

**OPINION ENTERED: November 19, 2013**

CLAIM NO. 200200578

ST. JOSEPH HOSPITAL PETITIONER

VS. **APPEAL FROM HON. STEVEN G. BOLTON, ADMINISTRATIVE LAW JUDGE**

ST. CLAIRE MEDICAL CENTER, INC.
DEBI MAYSE
and HON. STEVEN G. BOLTON,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

**OPINION**
**AFFIRMING**
* * * * * *

BEFORE: ALVEY, Chairman, STIVERS and RECHTER, Members.

**STIVERS, Member.** St. Joseph Hospital ("St. Joseph") appeals from the June 19, 2013, opinion and order of Hon. Steven G. Bolton, Administrative Law Judge ("ALJ") resolving a medical fee dispute between St. Joseph and St. Claire

Medical Center, Inc. ("St. Claire") in St. Claire's favor.[1] St. Joseph also appeals from the August 1, 2013, order denying its petition for reconsideration.

In her Form 101 (Claim No. 1989-31637), Debi Mayse (“Mayse”) alleged she was injured while in the employ of Morgan County Appalachian Regional Hospital ("Morgan County") on July 30, 1989, in the following manner: "The Plaintiff was lifting a patient from a chair back to her bed and injured her back."

In the Form 101 (Claim No. 2002-00578) against Gateway Community Health Services ("Gateway"). Mayse alleged she was injured on June 19, 1995, while in the employ of Gateway in the following manner: "I am not exactly sure of the exact cause of my injury but during this time I was doing a lot of lifting and maneuvering. I had a rupture of L5-S1." The Form 101 indicates Mayse treated with Dr. Phillip Tibbs who ultimately performed surgery.

A third Form 101 (Claim No. 1998-62126) alleged that while in the employ of St. Claire she was injured on June 16, 1998, in the following manner: "Plaintiff and

[1] St. Claire’s medical payment obligor is the Kentucky Insurance Guaranty Association or KIGA.

another R.N. were attempting to pull up a 325 pounds [sic] man and she felt a pain and pulling in her back."

By order dated June 10, 2002, Hon. Lloyd Edens, Administrative Law Judge ("ALJ Edens") consolidated the three claims. All claims were ultimately settled in 2003.

On June 29, 2012, St. Claire through KIGA filed a Motion to Reopen and Form 112 Medical Fee Dispute. In its Motion to Reopen, St. Claire asserted as follows:

> 1. Treatment was rendered by St. Joseph Hospital on or about November 11, 2011. The treatment included sedation, Sacroiliac Joint Injection and Fluoroscopy. A copy of the statement for services was received by KIGA on January 23, 2012.
>
> 2. KRS 342.020(1) provides that, 'The provider of medical services shall submit the statement for services within forty-five (45) days of the date of treatment.' 803 KAR 25:096, Sect. 6 states, 'If the medical services provider fails to submit a statement for services as required by KRS 342.020(1) without reasonable grounds, the medical bills shall not be compensable.'
>
> 3. Movant submits that the statement of services was received seventy-three (73) days after the rendered treatment. No reasonable explanation was provided for the delay.
>
> 4. Based upon the above facts, the Movant believes the statement for service should be found not compensable.

By order dated September 19, 2012, Hon. J. Landon Overfield, Chief Administrative Law Judge (“CALJ”) noted a copy of St. Claire's Motion to Reopen was not served on plaintiff's counsel and passed the motion for 20 days. St. Claire re-filed its Motion to Reopen and Medical Fee Dispute on September 26, 2012.

By order dated October 17, 2012, the CALJ deemed St. Claire's Motion to Reopen/Medical Fee Dispute to have been filed on June 29, 2012, sustained the Motion to Reopen/Medical Fee Dispute, and joined St. Joseph as a party.

On November 13, 2012, the claim was assigned to the ALJ.

The March 12, 2013, benefit review conference order and memorandum listed reasonableness/necessity and "bills for medical services submitted more than 45 days after they were incurred" as the contested issues.

In the June 19, 2013, opinion and order, the ALJ resolved the medical fee dispute in favor of St. Claire Medical Center ruling as follows:

> This is a Medical Dispute. One of the Respondents joined herein is a treating provider, St. Joseph Hospital.
>
> The Plaintiff settled his claim in a Form 110 that was approved by a prior Administrative Law Judge on March 31,

2003. The work related injury listed on the Form 110 was “low back.” The Plaintiff’s diagnosis is “Recurrent L5-S1 herniation.” The percent of permanent partial disability is 0%. The Defendant/Employer agreed to entitlement to permanent disability benefits, past and future medical expenses, rights to vocational rehabilitation and any rights to re-open this claim.

On June 29, 2012, the Defendant filed a Form 112 Medical Dispute contesting that the medical care provider failed to present a statement for services provided within forty-five (45) days of the date of treatment as required by KRS 342.020(1) and 803 KAR 25:096(6). This was accompanied by Defendant’s Motion to Re-open to resolve a medical dispute and a Motion to Join St. Joseph Hospital as party defendant, supported by a St. Joseph Hospital medical statement for services rendered on November 11, 2011 and the Form 110.

On the St. Joseph Hospital medical statement for services rendered on November 11, 2011, it was file-stamped “Received” as of January 23, 2012 by K.I.G.A. This was seventy-three (73) days after the services [sic] rendered. The actual “creation date” on the statement was listed as January 18, 2012. The CALJ issued an order on September 19, 2012 passing the motion and granting the Movant/Defendant twenty (20) days to supplement the motion to re-open with requisite documentation to 803 KAR 25:012.

On September 26, 2012, the Movant/Defendant filed the same Form 112 Medical Dispute contesting that the medical care provider failed to present a statement for services provided

within forty-five (45) days of the date of treatment as required by KRS 342.020(1) and 803 KAR 25:096(6). This was accompanied by Movant/Defendant's Motion to Re-open to resolve a medical dispute, supported by St. Joseph Hospital medical statement for services rendered on November 11, 2011, the Form 110 and the CALJ order of September 19, 2012. The CALJ issued an order on October 17, 2012 that the Form 112 be deemed filed on June 29, 2012, sustaining the motion to re-open/medical dispute and joining St. Joseph Hospital as a party.

On March 1, 2013 the Respondent, St. Joseph Hospital filed the Business Computer Pad Entry Notes regarding the treatment surrounding the November 11, 2011 date of service. The Business Computer Pad Entry Notes are as follows:

a. 11/4/11-Viana Ramos notes: work comp note s/w Scott Webster at KIGA who verified that the claim is still open and the claims mailing address.
b. 11/10/11-Viana Ramos notes: per fax from Dr. Owen's office pc# verbal approval per Scott Webster.
c. 11/22/11-SSI, Special Menu notes: SSI Primary UB92 Claim Paper billed 11/22/11 Total charges- $40,886.45 payer- commercial.
d. 11/22/11-Lydia R. Bell- notes: Filed UB IB and MR to KY INS Guaranty Assoc.
e. 01/13/12-Carla F. Blake notes: called KIGA (502) 327-00819 and left a detailed message for Scott Webster (Adjuster) to please return her call regarding payment.
f. 01/13/12-Carla F. Blake notes: received call back from Scott Webster…he says they don't have this bill…we had received incorrect billing address when verifying billing info with adjuster on

11/4/11…placing on billers list with corrected address.

g. 01/18/12-SSI, Special Menu notes: SSI Primary UB92 Claim Paper billed 01/18/12 Total charges- $40,886.45 payer- commercial.
h. 01/18/12-Lydia R. Bell notes: Updated address and validated
i. 01/18/12-Lydia R. Bell notes: Filed UB IB and MR to KY INS Guaranty Assoc.
j. 02/20/12-Carla F. Blake notes: mailing appeal with UB, IB and complete records to KIGA…appealing timely filing sent claim history along with notepads 1 and 6.
k. 04/25/12-Carla F. Blake notes: Called KIGA and talked to Scott Webster…he states that they are not going to pay this bill because was not sent in timely…I told him we sent it and he said he spoke to Ms. Mayse and it is her understanding it went to Medicare first…I am sending this to Denice… I f/u up on a timely basis as with work comp I am told by the companies to give 30 days to be entered and processed…we billed on 11/22/11 and my f/u call was 1/13/12.. there were 3 holidays that fell during that time and several days we were closed as well as the insurance company…I appealed and they are still denying…
l. 05/03/12-Melvina Denice Brown notes: Spoke with Scott Webster in reference to the denial. He stated he did not give an incorrect billing address when he called and provided the info listed in the first note on the account. He stated he has already received an appeal and had spoken with their attorney and they stand behind their denial. I am going to speak with Jason in reference to the acct.
m. 05/08/12-Melvina Denice Brown notes: Reviewed appealed with Jason and mailing to KIGA today.

n. 07/06/12-Melvina Denice Brown notes: Reply – Referred for review please call KIGA to receive the status of the appeal.
o. 07/19/12-Melvina Denice Brown notes: This is now in litigation per Dept. of Workers' Claims…claim number 1998-62126 filed in her records…
p. 10/05/12-Nancy Hogue notes: Received documents regarding medical dispute…
q. 10/10/12-Tracy L. Brown notes: Reviewed medical dispute papers received. Forwarded this account to John Oakley.

Arthur Scott Webster testified by way of Deposition on April 16, 2013. Mr. Webster testified that he has been employed at Kentucky Insurance Guaranty Association since June of 1986. Mr. Webster testified that before he became the executive director he worked as a claims examiner. He testified that the function of the Guaranty Association is to act as a safety net for Kentuckians who find themselves with a claim against an insolvent insurance carrier. Guaranty Association steps into the shoes of that carrier, making payments in accordance with comp law and take [sic] the claim back to the estate of the insolvent insurance company.

Mr. Webster testified that it was his handwritten notes in Ms. Mayse's claim. He testified that he received the contested billing statement on January 23, 2013. When he received the bill he denied it by letter dated January 26, 2012 outlining the reason for denial.

On cross-examination Mr. Webster was asked to explain his note on the denial of January 26th. It reads: "Attorney advises denial of the November 11 '11 hospital charges based on the 45-day rule even though the procedure was pre-certified as acceptable, but he could

find no case law. Denial Medical." Mr. Webster denied talking to his attorney prior to denying the medical bill, he later admitted it appears he did talk to Chuck (attorney) prior to the letter of denial going out, but he did not remember that. He testified the letter was based in part on Chuck's advice.

Mr. Webster testified that no utilization review was done. He further testified that the pre-certification was [sic] request that they received over the telephone for a pump replacement due the pump being 28 years old and not working properly. So we just approved it, there was no formal peer review done or utilization review done. He testified that it was verbally approved.

Mr. Webster testified that he did not recall the telephone conversation with Viana Ramos of St. Joseph Hospital on November 4, 2011. He admitted to having phone calls at [sic] time and not noting them. He did recall talking to someone on October 7 and 25th regarding the surgery for the pump replacement.

Mr. Webster testified that he had [sic] didn't know how St. Joseph Hospital obtained the address of 922 Shelbyville Road. He stated that there is no such address. Mr. Webster testified that the denial of this bill is solely based on the technical 45-day denial.

Mr. Webster testified that he expected to receive bills regarding the pre-certified surgery. Mr. Webster stated they received a bill from the anesthesia group timely. The bill from Lexington Clinic was not timely filed and was denied. Several of their pain-management bills had been denied for

the 45-day rule.

On Re-examination Mr. Webster was asked what the correct address is for Kentucky Insurance Guaranty Association. Mr. Webster stated, “10605 Shelbyville Road, Ste. 101, Louisville, Kentucky 40223.

Scott Webster’s handwritten notes for the issue at hand are as follows:

a. 05/13/11-Dr. Nickerson suggest new pain pump may be needed sooner 10 yo…
b. 10/07/11-Precert. for pump-replacement – TC client she wants the ~~medication~~ replacement. There is nothing we can do to oppose it the pump is 10 yo.
c. 10/25/11-Attn. pump replacement precert.
d. 10/26/11-Client called re: pump replacement surgery lives 2 hr away wanted to know if she could get a motel room the nite before I told her that would be reasonable @ $100.00 & 1 meal.
e. 11/8/11-TC client allowed Rm for Thurs prior to surgery @ 6:45 uo to $100 1 meal for Thurs up to 30 & 1 meal Fri up to $25.00 receipts required
f. 01/13/12-TC Carla re: St. Joseph Health Care charge for DOS 11-11-11 $40,846.00. The bill was sent to the wrong address (9200 Shelbyville) she will send it here.
g. 1/16/12-TC client she advised hosp. billed Medicare for DOS 11-11-11 & admitted to her they had nc info.
h. 01/26/12-Atty advises denial of the 11-11-11 hosp. charges based on the 45 day rule even though the procedure was pre-certed is acceptable but he could find no case law denied medical.
i. 02/17/12-A St. Joseph Hosp. Rep. called to follow up on denied DOS 11-11-11 $40,886.45 for 45 days. Ms. Mayse may have a record of them billing Medicare.

The Rep. says no record of that but they did bill ~~somewhere~~ the 9200 address per my note of 1-13-12. Carla will go to her Boss & maybe the Ins. Dept. I paid Chuck Jobson to review the situation prior to denial. Because of the amount we may have to litigate. I told Carla that Ms. Mayse sends reimb requests once or twice a month and knows our address. My guess is that they got the address from the hosp. record.

A Benefit Review Conference was conducted on March 12, 2013 pursuant to notice. A formal hearing was conducted on April 18, 2013. The sole issue contested issue is the reasonableness/necessity for the bills for medical services submitted more than 45 days after they were incurred.

At the Formal Hearing Tracy Brown testified on behalf St. Joseph Hospital. Ms. Brown is the manager of the AR collections for commercial and non-government accounts at St. Joseph Health System. Ms. Brown testified to the St. Joseph Hospital Business Computer Pad Entry Notes. Ms. Brown testified that after the Workers' Comp cost to charge ratio adjustment was applied to the $40,886.45 the total adjustment amounted to $18,995.27, leaving a balance of $21,891.18.

Ms. Brown testified that the billing occurred on 11/22/11. The claim dropped to paper and it was filed, along with an itemized bill and medical records to Kentucky Insurance Guaranty to the address they had on file given at registration. Ms. Brown stated that normally they try to contact the insurance between 30 and 45 days if no payment is received. Ms. Brown stated that due to the high-dollar amount of

the claim we know that it takes additional time, so usually there's some additional time maybe before the call is made initially for them to do any audit that would normally be done on a high-dollar claim.

Ms. Brown testified that on January 13th Mr. Webster did state that they had not received the bill and verified that they had received incorrect billing address and the claim. The claim was updated and mailed out to the correct address on January 18, 2012.

Ms. Brown testified that the original billing statement was processed and sent out on November 22, 2011, 11 days after the procedure. Ms. Brown testified that she doesn't have any personal knowledge of any documents being returned.

Ms. Brown testified that the Registration Clerk obtained the address given on November 4, 2011 and the billing was sent to that address on November 22, 2011. When it was determined that KIGA did not received [sic] the billing statement and that it was sent to [sic] wrong address they redid the billing statement and sent it to the correct address.

Ms. Brown further testified that on 10/25/11 at 11:15 a.m., Mr. Webster verbally approved the surgery for pump replacement and there is a pre-certification from Lexington Clinic for the surgery.

The Defendant claims that St. Joseph did not timely file the billing statement. They did not provide any evidence that the billing statement was mailed to the wrong address and that their own computer records show that

this file was flagged for follow up on several different occasions prior to the 45 day requirement.

KRS 342.020 (1) states in pertinent part,

"… The employer, insurer, or payment obligor acting on behalf of the employer, shall make all payments for services rendered to an employee directly to the provider of the services within thirty (30) days of receipt of a statement for services. The executive director shall promulgate administrative regulations establishing conditions under which the thirty (30) day period for payment may be tolled. The provider of medical services shall submit the statement for services within forty-five (45) days of the day treatment is initiated and every 45 days thereafter, if appropriate, as long as medical services are rendered.…".

The regulation mentioned in the statute may be found at 803 KAR 25:096, section 6, which states, "Tender of Statement for Services. If the medical services provider fails to submit a statement for services as required by KRS 342.020 (1) without reasonable grounds, the medical bills shall not be compensable."

Thus, it would appear that the 73 day delay in getting a statement for services rendered to the payment obligor must be determined by the ALJ to have been reasonable under all the surrounding circumstances in order for the statement to be enforceable in the sense that the payment obligor has any liability for payment due to the lateness of the submission.

We need not cast aspersions on any witness to conclude that St. Joseph's was simply negligent in its handling of the billing. The intent of the statute and regulation is clear. The General Assembly intends that for medical services billed by medical providers to payment obligors such as KIGA under Kentucky's workers compensation system, such statements must be timely issued within the intent of the statute and regulation.

St. Joseph's argues that it is exempt from the obligation in this case because the bill was submitted to the wrong address. Unfortunately, there is no evidence in the record that an earlier and timely statement was returned as undeliverable. Why that is so, we can only speculate.

At the hearing, St. Joseph's representative testified that a representative from KIGA, Scott Webster, provided a billing address on November 4, 2011 to which the hospital's claim could be said [sic] for payment. The hospitals [sic] position is that Mr. Webster provided an erroneous address. The billing statement was sent to that address and the hospital did not realize its error until after the 45 day period had expired.

The problem with that explanation is that there is no documentation contained in the record that supports it and there is no way of knowing if the person who answered the telephone to Mr. Webster's call.

As counsel for the defendant has artfully stated, the timeline in the evidence does not support St. Joseph's argument of reasonableness. Assuming

that a statement for services performed on November 11, 2011 was sent to an incorrect address on November 22, 2011 and returned as undeliverable 10 days later, that would be 21 days after the date of service, leaving 24 days to obtain the correct address and send a bill thence.

Assuming arguendo that no delivery was made on the erroneously addressed statement, St. Joseph's own computer records show that this file was flagged for follow-up on December 16, 2011 or 35 days after the date of service. This left St. Joseph 10 days to resubmit the bill. The computer note for December 16, 2011 shows that no action was taken on that date.

The next St. Joseph record shows that the file was flagged for December 29, 2011. This is 48 days after the date of the rendering of the service, but close enough to take immediate action. However, as December 29 was 37 days after the first bill was claimed to have been mailed to the incorrect address, St. Joseph's should have received payment according to the requirements of the statute.

The next flagged note was a St. Joseph computer entry of January 4, 2012 some 54 days after the date of service and 43 days after the original bill was sent. No action was taken.

The next flagged note was January 13, 2012. This is 63 days after the date of service and 52 days after the original bill was sent according to St. Joseph's. On that date, Scott Webster was called and informed St. Joseph that as of January 13, 2012 KIGA had not received a bill for the procedure to Ms. Mayse. Five days later (1/18/2012)

> a follow-up bill was sent that was not received until January 23, 2012 which was 73 days after the day of treatment. The ALJ finds that the statement of facts set out herein above, which have been distilled from the record as a whole and which the ALJ finds to be persuasive do not support a ruling that the efforts of St. Joseph's Hospital to submit a timely statement for medical services rendered on behalf of Ms. Mayse to the payment obligor were reasonable under all of the surrounding circumstances.
>
> The issuance of the statement for medical services some 73 days after the day of treatment was not reasonable under all of the surrounding circumstances and therefore violates the provisions of KRS 342.020 (1) and 803 KAR 25:096, Section 6. Therefore, it is not compensable.
>
> **It is therefore ordered** that the medical dispute be, and it is hereby resolved in favor of St. Clair [sic] Medical Center, Inc.
>
> **It is further ordered** that St. Clair [sic] medical [sic] Center Inc. be, and it is hereby relieved from the obligation to pay the outstanding statement for medical services rendered by St. Joseph's Hospital for an [sic] on behalf of Debi Mayse.

St. Joseph filed a petition for reconsideration asserting the ALJ's decision is "very harsh in light of the facts." By order dated August 1, 2013, the ALJ denied St. Joseph's petition for reconsideration.

On appeal, St. Joseph argues as follows:

KRS 342.020(1) indicates that a statement for medical services shall be submitted within forty-five (45) days from the date of treatment. The regulation promulgated under that statute allows for consideration of reasonable grounds when responding to this issue. Surely in the case at hand, the business office of St. Joseph Hospital did reasonably submit its charges for payment consideration. Apparently the initial statement for services submitted on November 22, 2011 never reached its destination nor was it returned to the hospital. The original address indicated as 9922 Shelbyville Road is not far from 10605 Shelbyville Road and it is surprising that the Postal Service couldn't deliver it. Be that as it may, have we reached a point where we penalize medical providers who make a clerical mistake? The case at hand involves a pre-approved surgical procedure that was performed and the insurance carrier had even anticipated a higher charge than that received. Counsel would not have [sic] the same argument with a provider that performed a procedure without pre-authorization and then filed a statement for services beyond the 45 day rule. Although the statute provides 'shall' language the regulation provides for 'reasonable grounds' which should include a clerical mistake for the insurance company's address. In its brief before the Administrative Law Judge Respondent indicated that 48 days after the date of service would be well within the margin of error by [sic] 73 days was not (Respondent's Brief at pages 6-7). What constitutes a reasonable margin of error and is a clerical error not within that period of time?

It is important to note the central dispute in this appeal is primarily an issue of fact and the ALJ's inference regarding what comprises "reasonable grounds" pursuant to 803 KAR 25:096(6). That is, do the reasons for St. Josephs' delay in submitting a timely statement for services pursuant to KRS 342.020(1) comprise "reasonable grounds"? 803 KAR 25:096(6). The ALJ, after reviewing the factual circumstances surrounding the delay, ultimately determined that the facts "do not support a ruling that the efforts of St. Joseph's Hospital to submit a timely statement for medical services rendered on behalf of Ms. Mayse to the payment obligor were reasonable under all of the surrounding circumstances." This Board is not a fact-finding tribunal. *See* KRS 342.285. The ALJ, as fact-finder, determines the quality, character, and substance of all the evidence and is the sole judge of the weight and inferences to be drawn from the evidence. Square D Company v. Tipton, 862 S.W.2d 308 (Ky. 1993); Miller v. East Kentucky Beverage/Pepsico, Inc., 951 S.W.2d 329 (Ky. 1997). Thus, this Board will defer to the ALJ's fact-finding and the resulting inference regarding whether reasonable grounds existed for the failure to timely submit a statement for medical services.

St. Joseph's assertion in this medical fee dispute, as set forth in its May 20, 2013, brief to the ALJ, is that it did "reasonably submit its charges for payment consideration." It claims as follows: "Apparently the initial statement for services submitted on November 22, 2011 never reached its destination nor was it returned to the hospital." However, as noted by the ALJ, "there is no evidence in the record that an earlier and timely statement was returned as undeliverable."

Consequently, the ALJ looked at the evidence in the record, including St. Joseph's records indicating when the file was flagged for follow-up. A review of the record reveals evidence, in the form of computer entries, that is consistent with the ALJ's findings that 35 days, 37 days, and 54 days after Mayse's November 11, 2011, surgery the file was flagged for follow-up and no action was taken. This documentation is attached to the April 18, 2013, hearing transcript. Finally, on January 13, 2012, St. Joseph's records indicate as follows: "AND LEFT DETAILED MSG FOR SCOTT WEBSTER (ADJUSTER) TO PLEASE RETURN MY CALL REGARDING PAYMENT." The next record, also dated January 13, 2012, indicates as follows: "Webster...he says they don't have this bill...we had received incorrect billing address when verifying billing info with adjuster on

11/4/11...placing on billers list with corrected address." Finally, a record dated January 18, 2012, states as follows: "SSI Primary UB92 Claim PAPER BILLED 01/18/12 Total Charges- $40886.45 Payer- COMMERCIAL." Consistent with the ALJ's findings, Arthur Scott Webster testified at the hearing that the bill was finally received by the Kentucky Insurance Guaranty Association (KIGA) on January 23, 2012, 73 days after Mayse's surgery was performed on November 11, 2011. A copy of the November 11, 2011, statement for services, date-stamped by KIGA on January 23, 2012, was filed in the record.

As the ALJ's fact-finding is supported by the record and as his decision (i.e. the delay is not reasonable) is supported by substantial evidence, this Board would be overstepping its authority were we to disturb these findings. In order to reverse the decision of the ALJ, it must be shown there was no evidence of substantial probative value to support the decision. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986). As there is substantial evidence supporting the ALJ's resolution of the medical fee dispute in favor of St. Claire and his finding the statement for services rendered on November 11, 2011, is not compensable pursuant to KRS

342.020(1) and 803 KAR 25:096, Section 6, this determination will not be disturbed.

Accordingly, the June 19, 2013, opinion and order and the August 1, 2013, order denying St. Joseph's petition for reconsideration are **AFFIRMED**.

ALL CONCUR.

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